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ABSTRACT

Intended for personnel of ambulatory health care facilities, the manual provides guidelines for the detection, prevention, and treatment of child abuse and neglect cases. Provided in the introduction is a statement of purpose, a brief history of child abuse, a definition (from the federal law), and incidence estimates. Identification is discussed in terms of general signs (such as incongruities in a parental report); signs of abuse in children (broken down into abuse, neglect, and sexual abuse and by whether or not emergency action is required); signs of abuse in the caregiver (such as current behavior, current living situation, and care of other children); and the need for a detailed medical work-up and a non-judgmental interview with the parent. It is stressed that the abuse need not be proven before being reported. Procedures, followup, and treatment in planning for the abused child and his family are examined. Possible preventive measures such as providing support services to very young parents or parents of handicapped children are suggested. The need for inservice training, orientation of new staff, coordination with other agencies, and education of the public is emphasized. Recommended is an evaluation procedure consisting of the collection of service statistics, process evaluation, and program evaluation. Stressed is the importance of community coordination among agencies, lay groups, and providers of such services as "hot lines". Appended is a list of resources including sources of general information and audio-visual aids, parents organizations, and bibliographic references. The Federal act, "Child Abuse Prevention and Treatment Act" (Public Law 93-247) is reproduced in the appendix. (DB)

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CHILD ABUSE / NEGLECT

A Guide for
Detection, Prevention, and Treatment
in BCHS Programs and Projects

EC 103 467

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
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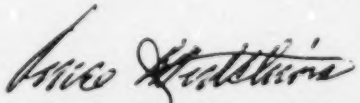
PREFACE

As a part of the commitment of the Bureau of Community Health Services (BCHS) to the comprehensive approach to the health care of children, the neglected and abused child is of particular concern. Every BCHS supported ambulatory health care facility should have as a part of its services the detection, prevention and treatment of neglect and abuse of children.

Only for little more than a decade has the extent of this problem been revealed. The National Center for Child Abuse and Neglect concludes that child abuse in this country has now reached epidemic proportions. In 1975, the latest year for which data is available, there were reported 311,000 cases of child abuse in the United States and of these approximately 450 resulted in death.

The phenomenon of abuse is not merely a medical problem. Its ramifications expand to include social and law enforcement agencies and often the courts as well. In order to assist Bureau supported projects to meet their responsibilities for the abused child, we have prepared this guide.

Under the Chairperson, Elizabeth Elmer, a group of experts in child abuse and neglect met at the School of Public Health, University of Pittsburgh to develop the draft of this guidance material. Representatives of the disciplines of Law, Medicine, Medical Social Work, Nutrition, and Nursing participated in the Pittsburgh meeting. The draft was sent to a sample of all BCHS programs and projects as well as to community and university experts for comments. The completed guide is for the use of all BCHS programs and projects, which are deeply committed to improving the health and welfare of our Nation's children.



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CHILD ABUSE--A GUIDE FOR BCHS SUPPORTED PROGRAMS AND PROJECTS

I. INTRODUCTION

A. Purpose

The problem of the physically abused and neglected child and his or her family is a special concern of the Bureau of Community Health Services (BCHS) because of its commitment to early treatment and to the prevention of illness. Medical settings, including the health programs funded by BCHS throughout the country, provide many of the treatment services often required by the abused child. In addition, medical and health care staff are sources for identifying potential and suspected abuse and neglect; the medical profession is designated in the majority of the state reporting laws as the principal group for reporting suspected cases.

This guide is designed for professionals working in BCHS supported facilities. Its overall purpose is to assist BCHS supported programs in developing more effective systems for the identification and management of child abuse and neglect. The immediate objective of the guide is to:

1. Summarize general information about abuse that may be useful to BCHS programs;

2. Discuss identification and reporting, which are mandated activities of health facilities;

3. Present methods of management;

4. Discuss intra-agency and community education and other activities that might be undertaken by individual programs;

5. Emphasize the necessity for coordination with other community resources;

6. Offer a brief summary of resource material.

B. History

Various authors have pointed out the existence of child abuse over many centuries in virtually all societies. (Helfer and Kempe, 1968.) Infants have been killed at birth to spare their parents the trouble of rearing them, to control the population, or to eliminate those with defects. Children have been bought and sold, tortured, exhibited, and exploited. Even in the past

hundred years countless children, some as young as 3, have labored 10 to 16 hours a day in mines, mills, and sweat shops, under shocking conditions.

Only recently have we come to understand that children as well as adults have rights that must be protected and nurtured. One of the obvious prerogatives of the young is the right to grow and develop free of physical and mental abuse or gross neglect. However, governmental agencies have traditionally been loathe to interfere with parental methods of childrearing. It was only in the 1960's that the extent of child abuse became evident in Western societies. Ultimately, this revelation led to the passage of laws mandating the reporting of abuse in 49 States and the District of Columbia, and encouraging reporting in the 50th State.

C. Definition

This guide utilizes the definition found in the Federal Child Abuse Prevention and Treatment Act (Public Law 93-247):

> Sec. 3. For purposes of this Act the term "child abuse and neglect" means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary of Health, Education, and Welfare.

D. Incidence

It is impossible to state accurately the true incidence of abuse. Few cases are reported when they involve middle or upper class families; abuse may masquerade as accident ("He fell down the stairs"); and many professionals fail to perceive the outline of abuse even when it is clear. The best estimate appears to be that of Light (1973), who concludes that one out of every 100 children is physically or sexually abused or severely neglected.

It is important to identify abuse as early as possible. Without intervention, mistreatment is likely to reoccur and mortality and morbidity to increase. Abused children are especially prone to later intellectual and emotional difficulties, and it has been shown that they frequently become abusive parents, thus perpetuating the cycle of abuse.

E. Responsibility of community

The phenomenon of abuse is by no means a purely medical problem but touches law enforcement, social work, and judiciary in ways

that may be more or less significant, depending on the individual case. The State reporting laws implicitly recognize the multiple facets of child abuse by placing the responsibility for dealing with it on the community and its appointed agents. The establishment of responsibility in the community implies that agencies and institutions will work collaboratively on behalf of these children and families.

II. IDENTIFICATION

A. General

Unfortunately, we have no laboratory tests for abuse like those for deleterious conditions, such as, PKU (phenylketonuria). Identification depends almost entirely on the practitioner's awareness of the possibility that people can hurt their children. Thus recognition is a crucial area that demands some introspective ability, much study, and use of as many indicators as can be found.

The first clue to abuse is often recognized in some kind of incongruity: a history that won't hang together; a twisting fracture as a result of a simple fall; observation of a parent exercising a child by stretching an arm almost to the breaking point. Inconsistence or inappropriateness should alert the clinician to the possibility of abuse and the need for especially careful history and observation.

Suspicion of abuse usually rests on several indicators taken together. For example, the child's injury in itself may be peculiar, his older sibling may have been treated for many accidents, and the parent's attitude toward the young patient may be hostile and belittling.

Most clinicians who are faced with the possibility that a parent has mistreated his or her own child will react with understandable anger or disbelief. If allowed to run unchecked, such emotions can strikingly reduce the clinician's ability. Most abused children can be helped only through their parents. Since abusive caretakers have had little experience with trust, they are quick to sense criticism and usually respond with heightened defensiveness. Whoever works with them will need objectivity and sensitivity along with the ability to perceive them not only as people with rights but also as the grown-up victims of neglect or abuse suffered during childhood.

The personal strains of relating to abusive parents are one of the many reasons for emphasizing the importance of the multidisciplinary team. To consider abuse as a serious possibility is utterly foreign to the thinking of most health professionals; support from a team, or even from one peer, is most desirable and welcome.

B. Some indicators of child abuse

As noted in the definition contained in the Federal law, abuse may be physical, mental, or sexual. Neglect is also defined very broadly. However, not all States specify the same categories. (The laws are summarized in De Francis, 1974.)

Amid the welter of definitions and ambiguous terms, health professionals need a systematic approach to help identify the children and families who may be involved in abuse.

Abuse is like a burn in that it may represent different levels of significance: first, second, or third degree. Each level dictates the kind of action required; for example, a third-degree burn is treated as an emergency while a first-degree burn can do with less immediate attention. The examples given are not intended as an exhaustive list but as illustrations of the signs suggesting appropriate levels of action.

1. Signs of Abuse in Children

EMERGENCY ACTION REQUIRED

(The child usually requires hospitalization)

ABUSE	Any injury in an infant under 12 months of age.*
	Gross or multiple injuries in a child of any age.
	Repeated injuries. Fractures in various stages of healing.
	Intra-cranial injuries.

*Children under this age are considered especially vulnerable because of the incomplete stage of maturation. It is always advisable to hospitalize such a child to permit a thorough exploration of the family's nurturing capacity.

NEGLECT	Unexplained weight loss.
	Severe malnutrition or failure to thrive, especially in very young children.
	Dehydration under unusual circumstances.
SEXUAL ABUSE**	Venereal disease or signs of genital trauma in children unable to understand the nature of the sex act.

**Many States do not yet specifically designate sexual abuse as reportable. It is included here because the Federal law includes it, because the trend among the States is in this direction, and because these are families and children who need help.

ACTION REQUIRED, NO EMERGENCY

ABUSE	Minor bruising about the face.
	Report or signs of excessive corporal punishment.
NEGLECT	Signs of poor care, e.g., diaper rash, hunger.
SEXUAL ABUSE	Veneral disease or signs of genital trauma in children able to understand the nature of the sex act.
	Exploitation of child, e.g. permitting the child to work in a massage parlor.

Early warning sign. To prevent abuse is far better than to detect it. One possible warning sign is severe lag in development. This could stem from a variety of causes, one of them lack of stimulation and attention from the caregiver. A child would not be reported as abused, of course, simply because of a lag in development; however, he might be seen more frequently and extra time might be spent to explore the quality of his environment, in the hope of locating and remedying a family imbalance that could lead to child abuse.

2. Signs of Abuse in Caregiver

Indicators of possible abuse by a caretaker are not categorized into levels of action, as are those in children, because current knowledge is too imprecise. Instead, pertinent information about the caregivers is grouped in several broad areas.

a. Current behavior in relation to the child's condition:

Inappropriate affect, e.g., an injury to the eye appears unimportant to the parent or caretaker.

Inadequate or conflicting history of the injury, e.g., the caregiver may not be able to explain a fractured femur in a 6-month-old; or different accounts are given concerning who was present at the time of the injury.

Failure to seek medical care promptly, e.g., a child with a broken arm may not receive needed medical attention for one week.

b. Observation of interaction with the child:

Inappropriate demands and expectations of a child, e.g., a 12-month-old does not stay dry at night.

Unreasonable and inappropriate discipline, e.g., a 3-year-old is beaten for failing to say "Thank you."

Angry, impulsive behavior, e.g., slapping, kicking, belittling.

c. Current living situation:

Stress such that the parent feels unable to cope.

Isolation, feelings of having nobody to turn to.

Inadequate support, e.g., insufficient income, poor health, insufficient medical resources.

Abuse of drugs or alcohol.

d. Care of other children:

Other children are in poor physical condition, are doing poorly in school, have been removed from the home, have sustained many accidents, or have been suspected of being abused.

e. Childhood history of caregiver:

Inconsistent nurturing, e.g., lived outside own home for protracted periods of time.

Neglect or abuse; excessive discipline.

f. Relationships with other agencies in the community:

History of impulsive and immature behavior.

As previously noted, the items mentioned above are intended as examples; it is possible to add many more, according to the clinician's experience. And no one indicator in itself is sufficient. A family that is abusing one or more children is in serious trouble that will be reflected in more than one area.

An early warning sign that should be taken most seriously is the mother who repeatedly telephones or brings a well baby to the clinic, stating that he is ill or making a trivial complaint. This is a cry for help that can be ignored only at the peril of the child and the despair of the parent.

C. Work-up

When abuse is suspected, the work-up should be especially detailed and complete. If indicated, skeletal survey by X-ray and color photographs repeated at suitable intervals should be part of the work-up. The record should note parents' complaints about the child's condition as well as the details of the physical examination.

Interviews with the parents should be non-judgmental and non-accusatory in tone. Abusive parents are known to be lonely, isolated people; what they need least is criticism. It may be helpful to the interviewer to keep in mind what this parent must have undergone as a child.

Interviewing the parents separately and also together is a means of learning about family interaction. In the same vein, observing parent and child together provides valuable data.

III. REPORTING

A common misapprehension among health professionals is that abuse must be proven before being reported. According to the laws of most States, suspected abuse must be reported. Investigation as to "who done it" is outside the function of the health facility and should be left to the agency designated to receive the report and to confirm or disprove the suspicion.

Reporting to a designated agency has several values: For the child, it offers immediate protection, if needed, by means of removal to a shelter or a foster home. For the family, reporting can be supportive; frequently, families tell of their relief at no longer having to bear the burdens of child-rearing alone. Reporting also is a way to effect entry for the family into the human services system, where members stand a possibility of receiving the multiple services they need. Finally, when combined with other positive steps, reporting may lead to remedying the situation by interrupting the cycle of the abused child becoming the abusive parent.

In addition to reporting, it is important for the health agency to have written guidelines, available to all staff, concerning what is to be reported, by whom, to what agency, at what interval after the abuse is suspected. (The individual State law will determine some of these items.) It is especially important that one person in each BCHS supported facility be responsible for making the final decision to report and for carrying out the decision. A multi-disciplinary team is most helpful in arriving at the decision, but the ultimate responsibility should belong to one designated staff person.

Once the decision to report child abuse has been taken, should the parents be told? The answer is a resounding yes. Parents need to understand the reasons for reporting and what will happen next, based on as clear an explanation as the clinician can give. Telling a parent about an abuse report means treating him or her with respect, sometimes the first experience of this kind in a very long time. Much depends of course on the tone and attitude of the clinician; real concern and regard for the parent do come through regardless of the words.

Health professionals sometimes view reporting of child abuse as punishment or abandonment of the parents. A report does not mean that the parents automatically go off to jail; rather, it is a way to begin clarifying the kind of care the child is receiving and helping the caregivers, if at all possible, to provide more appropriate care. If communication to the parents is tactful, the ongoing relationship of the clinician with the parent need not be ruptured. Several reports in the literature affirm that parents have continued to relate to the clinician who had the responsibility for reporting them. But whether or not the parent sees the same person, the health facility should continue to offer care to the family to insure continuity of care at a time when other services may enter and disappear rapidly.

IV. PLANNING FOR THE ABUSED CHILD AND HIS FAMILY

A. Procedures

Each BCHS agency has a responsibility to identify potential and actual abuse and to report suspected cases. Further activity will depend on a number of factors including the degree of involvement that the agency wishes to undertake. Whether involvement is limited or extensive, it is vitally important that the agency have a carefully thought out plan of action and clearly assigned responsibility for each phase of contact with the abused child and his family.

In some facilities, one person may assume the task alone. At a minimum he will need someone in the court and someone in the child protection agency who can consult with him. The preferred method of dealing with abuse is through a team. This allows responsibility to be shared and offers support to persons engaged in an arduous task. The core members of such a team are physician, nurse, and social worker. Others may include a health educator, occupational therapist, physical therapist, psychiatrist, lawyer, police officer and/or nutritionist. The lawyer can act as an impartial advisor to the team concerning the rights of the child and of his family; he may prepare briefs or petitions for court hearings, and act in court on behalf of the health agency. He can also help other members of the team prepare and present evidence in a manner acceptable to the court.

Each of the following tasks should be the explicit responsibility of one team member: supporting the suspicion of abuse, reporting, planning the immediate disposition of the case (hospitalization, further work-up, referral), and reviewing the case at a later time. One member should be appointed team coordinator. The assignment of tasks should be in writing, available to all members of the facility, and should be binding for a specified period of time.

The entire scope and content of the program should be incorporated in a written plan that is available to all personnel and to the community resources likely to be involved in the problem. These include the child protection agencies, especially the public agency to which reports are made, social agencies, other health facilities, the schools, the police, and the courts. Special policies and procedures may be posted for reference in strategic service delivery areas, emergency clinics, outpatient clinics, and the like. These should include brief information concerning the reporting procedure and names of consultants.

In addition to their roles in giving direct help to child and family, appropriate functions of the team as a whole are to:

Develop policy and program in relation to abuse;

Write procedures for the agency;

Update the procedures at regular intervals;

Assist with diagnosis and planning;

Coordinate services both within the agency and with other community resources;

Help develop new services appropriate for abused children and their families;

Orient new staff;

Plan and execute in-service training;

Assist in community education;

Provide objectivity and support for each other.

The frequency of team meetings will of course depend on the number and complexity of abuse problems. A team may meet only on call, as needed, or several times a week. An agenda distributed prior to the meeting alerts staff to material for discussion. Careful minutes and recording of all decisions help chart the progress of each case.

One of the most critical aspects of any discussion of abuse, including the team meeting, is the issue of confidentiality. Discussions should be restricted to specified persons who are committed to the safeguarding of sensitive information. Paraprofessionals often need extra help with the concept of confidentiality because the allegedly abusive parents may live in the same neighborhood or may be social acquaintances.

Full and accurate records written by physicians and other appropriate staff are necessary to provide comparison between different points in time with respect to the progress of the family, the development of the child, and the usefulness of various services. Records should note referrals, services provided, and other specifics of the plan for the family. As previously noted, details of the physical findings and other evidence supporting the suspicion of abuse are of special importance if the case should come to court. (Because it is possible that the court case will not come up for some months, detailed record material is essential.)

B. Followup

A crucial task is followup. Systematic review of old cases helps determine progress or the lack of it and may prevent children or their families from being lost. It can also be informative to examine those cases in which it was eventually decided that no grounds existed for suspecting abuse. The ambiguous nature of abuse and decisions about it suggest that all relevant determinations be scrutinized at a later date in order to extend knowledge.

The ideal interval of time before followup is a moot point. If it is too short, evaluation may occur before the plan for the family has had time enough to work, and the results may appear to require a change in plans, which would be premature. If the interval is too long, the child or the family may be lost or may needlessly suffer additional difficulties. Probably the best rule of thumb is to set the followup interval according to the perceived needs of the case. Whatever interval is chosen, followup should be conducted on each case.

C. Treatment

Treatment should only be undertaken with the full realization that it requires far more than words. Treatment is long, arduous, and uncertain as to outcome. Experts in the field concur that traditional methods which leave initiation of requests for help and responsibility for following through with recommended treatment to patients and families do not work; persistent outreach is necessary.

A comprehensive treatment program includes the following:

1. A good home evaluation.

2. Early diagnosis of parenting ability, with planning stemming from the diagnosis.

3. Group support for the therapist.

4. Group and individual treatment for the parents.

5. Provision for the therapist to treat no more than three to four cases at a time; the therapist should not be confined to handling only abuse.

6. A positive relationship with the public welfare agency and other community resources, for example, day care facilities or crisis nurseries, which can provide relief for the caretakers.

7. Provision of transportation for the parents, if needed.

8. Long-term commitment (often several years) to each treated case.

Many BHCS supported facilities are not geared to provision of all of this highly specialized care. Many communities do not have a single agency equipped to carry out all these functions. The BCHS staff has to decide whether to be the principal agent for the entire treatment itself or to work with other community resources toward a joint inter-agency, agency-community effort. Existing resources may be adapted, new ones may be added, with interested groups providing parts of a coordinated program. If the BCHS facility is not prepared to take major responsibility for coordination, then it must make certain that another community agency, perhaps an agency with legal responsibility for protection services, assumes responsibility to assure continuity of care.

V. PREVENTION

It is painfully apparent that we do not yet know how to prevent the occurrence of child abuse. Nevertheless, it is urgent to keep a lookout for any possibility of prevention. Early warning signs have been mentioned in a previous section; in addition, it is known that abused children include a disproportionate number of prematures. The health facility might pay special attention to the provision of transportation to prevent interference with the process of bonding between mother and baby; observe interaction between father, mother and baby and offer special help if problems are noted. Similarly, the mother who lacks relatives, friends, or neighbors to whom she can turn in time of trouble should alert staff to the need to find ways to provide support and counsel.

Very young parents and parents of handicapped children should receive special attention.

Parents who have had little experience in being nurtured are another vulnerable group. An example is retarded parents who have been reared in institutions and thus have lacked a pattern for parenting.

Adequate preventive measures include looking beyond the abused child to his siblings. A suspicion of abuse should routinely set in motion procedures to evaluate the growth, development, and emotional state of other children in the family. Early attention may serve to spare the siblings the hurtful experience of the abused family member.

As more is known about the phenomenon of abuse and how it is set in motion, the precursors will emerge. BCHS facilities can have a part in contributing to new knowledge in this difficult area.

VI. EDUCATION

To support a high-level program in the identification and management of child abuse, education is essential for the following categories of personnel: others in the BCHS facility not on the team dealing with abuse, new agency staff, personnel of outside agencies, and the lay public.

A. In-service training

Ideally, at least one person in the BCHS facility should have training and experience in the management of child abuse, and this person should be responsible for seeing that other personnel in the agency receive adequate training. At the present time, however, not enough trained people are available to take care of all the needs, and indeed the responsible agency person may need additional training. It is often possible to engage a consultant from the local area on a regular basis until a satisfactory level of training is achieved. Another resource is the educational programs that are beginning to be offered by various States. Seminars and workshops are sometimes available under sponsorship of medical centers, child protective agencies, and other interested professional and lay groups. "Self-help" instructional materials including audio-visual aids are available for a modest fee. (See Section IX of this Guide.)

Whatever type of teaching is chosen, it should be provided to staff of BCHS supported agency on a periodic, planned basis. The content will of course be determined by the needs of the staff and by the trainers but might well consist of deeper, more

detailed information concerning the material found in the preceding sections of this guide. Training should also be designed to keep the staff up-to-date on Federal and State developments as well as on changes in the agency program with respect to abuse.

In-service training should be addressed to paraprofessional as well as professional staff. In most facilities home visits are made by paraprofessionals such as case aides or health aides; they are therefore on the front line where they may unexpectedly stumble on evidence of abuse. Anticipatory guidance (a full explanation of what may be encountered and guidance for action provided before the worker needs to use the information) will enhance the handling of such a situation and will also give the paraprofessional a sense of support from the agency.

B. Orientation of new staff

As new staff join the agency, they should promptly receive information concerning abuse as part of their regular orientation. The written protocol developed by the agency should be part of the new person's information kit.

C. Other agencies

Continuing dialogue with other community agencies will help define the role that the BCHS facility can play in the education of personnel serving other agencies. In some communities the BCHS agency will be one of the primary sources of information for other agencies, particularly those in which abuse is an infrequent problem. In such instances the aim might be to inform the other groups about the existence of abuse, its identification, the mandatory reporting laws, and the fact that most abusive parents are not repugnant although the idea of abuse may be. Basic education for personnel in other agencies should be planned in cooperation with the child protective agency.

The BCHS facility should share its written procedures with any outside agency that has a part in the management of child abuse, and invite discussion from the other agency. This is especially important with the hospital serving as back-up for the BCHS facility. Sharing of information plus case discussions as the opportunity arises afford a method to educate, collaborate, and thus improve case management.

Certain groups in the community, for example, day care personnel and welfare workers, are in a strategic position to identify abuse at an early stage or to prevent its occurrence. The BCHS agency may conduct, or assist in conducting, training sessions for such groups. This could be mutually advantageous because the other groups can provide input to the BCHS trainers and may also become community resources for particular cases.

Knowledge gained in working with abused children and their families also needs to be fed back into the formal education system. It is desirable that health facilities maintain and encourage communication with professional schools such as social work, nursing, medicine, and law, to ensure that material concerning abuse is included in various curricula.

D. The public

Community education is another area where coordinated efforts by all interested agencies, including the BCHS agency are needed. This kind of education, which is never completed, demands repeated input, varied enough to be stimulating but uniform enough to have a cumulative impact. Efforts may be focused on the general population through the mass media or on target groups such as community service organizations through speeches, workshops and seminars.

Too frequently, sensationalism colors the reporting of news concerning child abuse. The general public is sadly uninformed about the lack of resources, e.g., a 24-hour hotline, crisis nurseries, homemaker services. Instead of concentrating on the lurid details of a particular case, the media could publicize the need for specialized services to help these desperate families as well as other young parents. The BCHS supported agency can assist by presenting to the media the positive aspects of parents who are struggling to rear children without the kind of support that other generations took for granted.

Very often, lay groups are seeking civic projects. Special educational programs for them may result in a cadre of volunteers who are dedicated to helping with child abuse, and who can perform a variety of useful tasks, occasionally including the establishment of new services.

Whatever the target population, whatever the technique of community education, two basic concepts apply: 1) Abusers are not monsters but people remarkably like other people; and 2) the provision of services and rehabilitation is a community responsibility that extends to <u>all</u> families, not to abusive families alone. To single out abusive families and provide them with special services not offered to others can have the effect of further isolating caretakers who are known to suffer from feelings of being isolated and unwanted.

VII. EVALUATION

Evaluation is the only way to learn how the BCHS effort related to abuse is functioning as a whole and in each of its parts. There are three components: The collection of service statistics, the evaluation of process, and the evaluation of program.

A. Service statistics

In planning services accurate statistics are invaluable. They reveal the total number of cases identified as possibly abused or neglected in a given span of time and the status of cases at some predetermined period after identification. Such information helps determine the number of staff needed, desirable qualifications and training, and their allocation within the program. Finally, service statistics are the basis for deciding on the amount of budget needed and the best use of it.

The following data are needed at a minimum:

Total number of abuse or neglect cases considered

1. Number reported
    a. Confirmed
    b. Not confirmed
2. Number not reported
    a. Considered high risk and closely followed
    b. Considered low risk, no special plans
3. Status of confirmed cases at a later period
4. Status of unreported, high risk cases at a later period
5. Status of unreported, low risk cases at a later period

B. Process evaluation

Process evaluation has already been touched on in the section titled "Followup." Essentially this means finding out how well the plans of the agency for each case are working in reality. Were the recommendations of the BCHS facility suitable and practical? What specific services were given by the BCHS supported agency or another agency? Did the family get what they seemed to need? e.g., a homemaker, counseling, day care.

Since other agencies in the community are usually involved, it is helpful to monitor events following referral: Are referrals viewed as legitimate by the other agency? by the family? How smooth is the case flow from one agency to another? Has the family been able to relate to the other agency? When referrals go in the other direction -- from an outside agency to BCHS supported agency -- the same kinds of questions should be raised.

Process evaluation also needs to attend to relevant information about the child. Six months after identification, where was the child living? What was his or her health status?

A written plan for each family is recommended because it can be checked at specified intervals (usually 3 to 6 months) for easy evaluation. In some facilities the plan is shared with the family. This requires judgment, especially if a poor prognosis is included.

C. Program evaluation

This is the means of identifying weak spots in the program or points where the program fails to meet the needs of the families and the community. Instead of dwelling on individual cases, program evaluation inquires about the entire abuse and neglect operation. The necessary elements for this kind of assessment are service statistics, process evaluation, and the thinking of the staff.

Among the questions to be asked are: How many abused children reported by the BCHS supported agency have been successfully protected in their own homes? How many remain outside their natural homes in either foster placement or institutions? Did some children go back and forth between home and other places? If so, why? Were termination of parental rights and adoption the outcome for some children? What age was the child when living arrangements were changed, and for what period of time did they hold?

At a specified length of time after identification, what is the health status of the children suspected of being abused? What about height, weight, general physical development? How many have permanent disabilities or have died as a result of mistreatment? How many have been re-abused? (A decrease in the rate of re-abuse would of course be a positive sign of the effectiveness of the total program.)

Did families continue receiving health care from the BCHS supported facility after they were reported for suspected abuse? How many families have improved to the point where they can manage their offspring without recurring violence? What kinds of services appeared to be most helpful?

When parents were unable to become more adequate caretakers, how soon was this recognized? What measures were taken at that point? Looking back, were there any predictive signs of either capacity or inability to change?

Unfortunately, what initially looks like a favorable outcome may fall apart a few months later. To obtain a truly long-range perspective, the living arrangments and the health status of the children and the progress of the families should be checked at regular points during a prolonged period, say five years.

The same questions need to be asked, perhaps fewer times, concerning those children whose situations were considered questionable but not sufficiently verified to report.

A thorough program evaluation provides factual markers to decide the worth of the endeavor and also shows how services may be altered to be more responsive to the varied and changing needs of the families the agency serves.

VIII. COMMUNITY COORDINATION

The concept of community coordination has been threaded throughout this document, but its significance in the management of abuse and neglect dictates a separate section as well. No one group has all the necessary resources for handling situations as complex and demanding as these; it is imperative to work together. The system for inter-group dialogue will be unique to each community because of variations in resources and the way they can be utilized. But it is obvious that several groups working together can do a better job than any single group. Further, abusive parents need to see that various groups can act in concert for the benefit of the entire family.

If possible, lines of communication among agencies should be opened before attempts are made to manage cases of abuse or neglect. This allows personnel to become acquainted without the stress of having to plan for a difficult case.

A. Agencies

The basic ingredients for inter-agency coordination are well known: openness and willingness to share, flexibility, and absence of "turfdom." Beyond those simple principles no reliable procedures can be set forth because agencies and personnel are so different from one community to another. The types of agencies that can profitably intermesh concerning abuse are health facilities, schools, day care centers and nuseries, community mental health centers, the police, the courts, legal aid groups, and of course child protection agencies. The latter are of consequence because of their mandated responsibility with respect to child abuse.

B. Lay groups

The lack of manpower makes the use of volunteers a priority. Groups such as Junior League, civic clubs, and others have been of great assistance in the past in helping develop and staff new community services. In addition, there are large pools of able and interested persons who can be mobilized to meet a demonstrated need. Such pools include teenagers, church groups, and middle-aged parents whose children are now independent. All volunteers of course need adequate training and continuous, skilled supervision. They should be compensated for transportation and other out-of-pocket expenses. Most of all, they need respect and recognition for their contribution. The fact that they are not on salary does not detract from their ability and should not detract from their sense of self-worth.

The concept of child advocacy has come into prominence in the past few years. The child advocate can often interest key persons in the community in tackling defined problems and can spur needed legislation. Like a gadfly, the role is to see that things get done. This could be a most meaningful task for individuals or groups who have a deep commitment to the solution of children's problems.

C. Useful services

A range of services, some new, some rediscovered, have emerged to help with child abuse. Those presented here are not intended as an exhaustive list but as examples that may stimulate innovative thinking. "Hot lines," previously referred to in this guide, are advertised telephone numbers to be used by anyone with a problem in a specific area. The purpose of a hot line designed to prevent or reduce child abuse is to immediately place a listening ear at the disposal of the anxious adult. People are encouraged to call and discuss disturbing behavior by a child or frightening, aggressive impulses the caretaker feels toward a child. Often, being able to talk to an understanding listener is sufficient to reduce the tension and allow the situation to simmer down. Sometimes referral can be made to an appropriate source of help; occasionally, the call concerns a crisis requiring immediate action such as police intervention. Most hot lines operate on a 24-hour, 7-day-a-week basis. They are often manned by volunteers working under professional supervision.

Some communities have developed "visit a friend" to care for children whose parents feel, for one reason or another, that they need temporary assistance in caring for their offspring. Some nurseries are set up only for emergency care, for example, when a parent fears the loss of control.

Institutional care for temporary placement of abused children with staff and programs to provide an opportunity for observation and specialized services for parents and children, have also been set up and may be used by agencies and courts for evaluation before a decision is made regarding a permanent plan of care.

Homemakers are not new on the American scene but have been less utilized here than in parts of Europe. There they are considered essential for keeping families together in times of stress, e.g., when a mother is hospitalized. For many abuse cases a homemaker could be the means of stabilizing the family. At the same time the responsible agency would have the opportunity of making a detailed exploration of the family's current problems and potential for change.

Somewhat related to the homemaker is the lay therapist currently being used in several communities. The lay therapist is usually a middle-aged woman (infrequently a man) who has successfully reared her family, and who wishes to continue her usefulness to others. Training is required for a lay therapist; it equips her to be a source of support to abusive parents until they are able to reach out to other supports in the community.

In many places, abusive parents have formed self-help groups similar to Alcoholics Anonymous. Some groups are national in scope, others local; some use professional consultation, others do not. Many parent groups believe they have successfully extended aid to other similar parents, thus forestalling further abusive behavior. Disinterested observers believe that the quality of leadership has a direct bearing on the effectiveness of the parent groups.

In some localities, parent groups might be developed or supported through coordinated efforts of the BCHS supported agency with other service agencies.

A number of news sheets on national or regional basis have been developed which are useful as a means of interchanging knowledge of new programs and research findings in the field of child abuse and neglect.

IX. RESOURCES

The aim in this section is not to provide a listing of all available resources but to indicate where material of various kinds may be found.

A. General information

Information may be obtained from:

National Center on Child Abuse and Neglect
Children's Bureau
Office of Child Development
P.O. Box 1182
Washington, D.C. 20013

The American Humane Association
Children's Division
P.O. Box 1266
Denver, Colorado 80201

National Center for the Prevention and
Treatment of Child Abuse and Neglect
University of Colorado Medical Center
1001 Jasmine
Denver Colorado 80220

B. Audio-visual aids

American Academy of Pediatrics
Infant and Pre-school Committee
1801 Hinman Avenue
Evanston, Illinois 60204

National Center for the Prevention and
Treatment of Child Abuse and Neglect
University of Colorado Medical Center
1001 Jasmine
Denver, Colorado 80220

In conjunction with others, the Center has prepared self-help materials that can be rented or sold. These are listed in a catalogue available from the above address.

C. Legislation

The Federal act, "Child Abuse Prevention and Treatment Act," Public Law 93-247, is reproduced in the appendix of this guide.

Individuals working in the area of child abuse should be familiar with the applicable State legislation. Copies of the State law may be obtained from your State representative or senator. State laws related to child abuse are summarized in:

Child Abuse Legislation in the 1970's, revised edition.
DeFrancis, Vincent and Lucht, Carroll L.
Denver: The American Humane Association, 1974.

D. Parents' Organizations

Information may be obtained from:

Parents Anonymous
2810 Artesia Boulevard
Redondo Beach, California 90278
(Phone: 213-371-3501)

E. References, general

The Battered Child
Helfer, R.E., and Kempe, C.H.
Chicago: University of Chicago Press, 1968.

"Child Abuse and Neglect: The Problem and Its Management,"
3 volumes, National Center on Child Abuse and Neglect

Volume 1, "An Overview of the Problem," Stock No. 017-092-00018-9, Price $1.50.
Volume 2, "The Roles and Responsibilities of Professionals," Stock No. 017-092-00017-1, Price $1.90.
Volume 3, "The Community Team, An Approach to Case Management and Prevention," Stock No. 017-092-00019-7, Price $2.60.

(Copies may be ordered from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, at prices shown.)

Helping the Battered Child and His Family
Kempe, C.G., and Helfer, R.E.
Philadelphia: J.B. Lippincott Company, 1972.

Abused and neglected children in America: A study of Alternative Policies. Light, Richard L. Harvard Educational Review 43: 556-598, November, 1973.

"Profile of Neglect: A Survey of the State of Knowledge of Child Neglect"
Public Services Administration
Social and Rehabilitation Service
U.S. Department of Health, Education, and Welfare
Washington, D.C., 1975.
(Superintendent of Documents Stock No. 017-065-00006-8, Price $1.20.)

"Protective Services for Abused and Neglected Children and Their Families, A Guide for State and Local Department of Public Social Services on the Delivery of Protective Services"
PSA, SRS, DHEW
Washington, D.C., 1977.
(Single copies available without charge from SRS, Room G-115, Mary Switzer Building, Washington, D.C. 20201.)

F. Sources of bibliography

National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857
(Ask for "Selected References on Child Abuse and Neglect.")

Public Services Administration
Social and Rehabilitation Service
U.S. Department of Health, Education, and Welfare
Room G-115, Mary Switzer Building
Washington, D.C. 20201
(Ask for "Child Neglect: An Annotated Bibliography," SRS, 76-23041.)

APPENDIX

Public Law 93-247
93rd Congress, S. 1191
January 31, 1974

An Act

To provide financial assistance for a demonstration program for the prevention, identification, and treatment of child abuse and neglect, to establish a National Center on Child Abuse and Neglect, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Child Abuse Prevention and Treatment Act". Child Abuse Prevention and Treatment Act.

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THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

SEC. 2. (a) The Secretary of Health, Education, and Welfare (hereinafter referred to in this Act as the "Secretary") shall establish an office to be known as the National Center on Child Abuse and Neglect (hereinafter referred to in this Act as the "Center"). Establishment.

(b) The Secretary, through the Center, shall—

(1) compile, analyze, and publish a summary annually of recently conducted and currently conducted research on child abuse and neglect; Annual research summary.

(2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of child abuse and neglect; Information clearinghouse.

(3) compile and publish training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect;

(4) provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the prevention, identification, and treatment of child abuse and neglect;

(5) conduct research into the causes of child abuse and neglect, and into the prevention, identification, and treatment thereof; and

(6) make a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity. Study.

DEFINITION

SEC. 3. For purposes of this Act the term "child abuse and neglect" means the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary.

DEMONSTRATION PROGRAMS AND PROJECTS

SEC. 4. (a) The Secretary, through the Center, is authorized to make grants to, and enter into contracts with, public agencies or nonprofit private organizations (or combinations thereof) for demonstration programs and projects designed to prevent, identify, and treat child abuse and neglect. Grants or contracts under this subsection may be— Grants and contracts.

(1) for the development and establishment of training programs for professional and paraprofessional personnel in the fields of medicine, law, education, social work, and other relevant

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fields who are engaged in, or intend to work in, the field of the prevention, identification, and treatment of child abuse and neglect; and training programs for children, and for persons responsible for the welfare of children, in methods of protecting children from child abuse and neglect;

(2) for the establishment and maintenance of centers, serving defined geographic areas, staffed by multidisciplinary teams of personnel trained in the prevention, identification, and treatment of child abuse and neglect cases, to provide a broad range of services related to child abuse and neglect, including direct support and supervision of satellite centers and attention homes, as well as providing advice and consultation to individuals, agencies, and organizations which request such services;

(3) for furnishing services of teams of professional and paraprofessional personnel who are trained in the prevention, identification, and treatment of child abuse and neglect cases, on a consulting basis to small communities where such services are not available; and

(4) for such other innovative programs and projects, including programs and projects for parent self-help, and for prevention and treatment of drug-related child abuse and neglect, that show promise of successfully preventing or treating cases of child abuse and neglect as the Secretary may approve.

Not less than 50 per centum of the funds appropriated under this Act for any fiscal year shall be used only for carrying out the provisions of this subsection.

Grants to States.

(b)(1) Of the sums appropriated under this Act for any fiscal year, not less than 5 per centum and not more than 20 per centum may be used by the Secretary for making grants to the States for the payment of reasonable and necessary expenses for the purpose of assisting the States in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs.

(2) In order for a State to qualify for assistance under this subsection, such State shall—

(A) have in effect a State child abuse and neglect law which shall include provisions for immunity for persons reporting instances of child abuse and neglect from prosecution, under any State or local law, arising out of such reporting;

(B) provide for the reporting of known and suspected instances of child abuse and neglect;

(C) provide that upon receipt of a report of known or suspected instances of child abuse or neglect an investigation shall be initiated promptly to substantiate the accuracy of the report, and, upon a finding of abuse or neglect, immediate steps shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect;

(D) demonstrate that there are in effect throughout the State, in connection with the enforcement of child abuse and neglect laws and with the reporting of suspected instances of child abuse and neglect, such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State will deal effectively with child abuse and neglect cases in the State;

(E) provide for methods to preserve the confidentiality of all records in order to protect the rights of the child, his parents or guardians;

(F) provide for the cooperation of law enforcement officials, courts of competent jurisdiction, and appropriate State agencies providing human services;

(G) provide that in every case involving an abused or neglected child which results in a judicial proceeding a guardian ad litem shall be appointed to represent the child in such proceedings;

(H) provide that the aggregate of support for programs or projects related to child abuse and neglect assisted by State funds shall not be reduced below the level provided during fiscal year 1973, and set forth policies and procedures designed to assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of State funds which would, in the absence of Federal funds, be available for such programs and projects;

(I) provide for dissemination of information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat instances of child abuse and neglect; and

(J) to the extent feasible, insure that parental organizations combating child abuse and neglect receive preferential treatment.

(3) Programs or projects related to child abuse and neglect assisted under part A or B of title IV of the Social Security Act shall comply with the requirements set forth in clauses (B), (C), (E), and (F) of paragraph (2). 49 Stat. 627; 81 Stat. 911. 42 USC 601, 620.

(c) Assistance provided pursuant to this section shall not be available for construction of facilities; however, the Secretary is authorized to supply such assistance for the lease or rental of facilities where adequate facilities are not otherwise available, and for repair or minor remodeling or alteration of existing facilities.

(d) The Secretary shall establish criteria designed to achieve equitable distribution of assistance under this section among the States, among geographic areas of the Nation, and among rural and urban areas. To the extent possible, citizens of each State shall receive assistance from at least one project under this section.

AUTHORIZATIONS

SEC. 5. There are hereby authorized to be appropriated for the purposes of this Act $15,000,000 for the fiscal year ending June 30, 1974, $20,000,000 for the fiscal year ending June 30, 1975, and $25,000,000 for the fiscal year ending June 30, 1976, and for the succeeding fiscal year.

ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

SEC. 6. (a) The Secretary shall, within sixty days after the date of enactment of this Act, appoint an Advisory Board on Child Abuse and Neglect (hereinafter referred to as the "Advisory Board"), which shall be composed of representatives from Federal agencies with responsibility for programs and activities related to child abuse and neglect, including the Office of Child Development, the Office of Education, the National Institute of Education, the National Institute of Mental Health, the National Institute of Child Health and Human Development, the Social and Rehabilitation Service, and the Health Services Administration. The Advisory Board shall assist the Secretary in coordinating programs and activities related to child abuse

Membership.

Functions.

and neglect administered or assisted under this Act with such programs and activities administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. The Advisory Board shall also assist the Secretary in the development of Federal standards for child abuse and neglect prevention and treatment programs and projects.

Report to President and Congress.

(b) The Advisory Board shall prepare and submit, within eighteen months after the date of enactment of this Act, to the President and to the Congress a report on the programs assisted under this Act and the programs, projects, and activities related to child abuse and neglect administered or assisted by the Federal agencies whose representatives are members of the Advisory Board. Such report shall include a study of the relationship between drug addiction and child abuse and neglect.

(c) Of the funds appropriated under section 5, one-half of 1 per centum, or $1,000,000, whichever is the lesser, may be used by the Secretary only for purposes of the report under subsection (b).

COORDINATION

SEC. 7. The Secretary shall promulgate regulations and make such arrangements as may be necessary or appropriate to ensure that there is effective coordination between programs related to child abuse and neglect under this Act and other such programs which are assisted by Federal funds.

Approved January 31, 1974.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 93-685 (Comm. on Education and Labor).
SENATE REPORT No. 93-308 (Comm. on Labor and Public Welfare).
CONGRESSIONAL RECORD, Vol. 119 (1973):
July 14, considered and passed Senate.
Dec. 3, considered and passed House, amended.
Dec. 20, Senate agreed to House amendments with amendments.
Dec. 21, House concurred in Senate amendments.

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